Proposed Board Policy Decision-Making Timeline

The following provides a potential high-level overview and timeline of important and timely policy decisions. This is not meant to be an exhaustive list, but highlights proposed timelines for decisions that will need to be made over the next several months.

It is assumed that Board Subcommittee meetings will be followed by a briefing to the full Board after each meeting.

Exchange Revenue Source/Sustainability

The Exchange needs to be self-sustaining by January 1, 2015 when federal grant funds are no longer available. The following outlines a process for the Board to design an appropriate and sustainable revenue source for the Exchange, as well as to meet the requirements laid out in HB 2319 to submit a report on sustainability to the Legislature by December 1, 2012.

April 2012: Financial Projections Report released – looks at general costs at operating the Exchange and offers high-level options for possible sustainability models.

May 2012: Staff prepares background information and briefs the Board.

May 2012: Finance/Admin/IT (F/A/IT) Subcommittee takes up sustainability discussion.

May 2012: Advisory Committee discusses assessments on plans as a revenue source for the Exchange. Committee looks at different ways plan assessments could be structured.

June 2012: F/A/IT Subcommittee hears recommendations from Advisory Committee.

July 2012: F/A/IT Subcommittee makes recommendations on possible options to full Board.

July 2012: Exchange staff work with consultant to further model those options selected by the Board as potential revenue methodologies, including how they are structure, how often they are collected, when collection begins and different estimates based on enrollment.

September 2012: Consultant presents modeling to the Board.

September 2012: F/A/IT Subcommittee and Advisory Committee further review consultant's models. The F/A/IT Subcommittee revises models.

October 2012: F/A/IT Subcommittee proposes recommendation on sustainability methodology to full Board.

November 2012: Full Board decides on final recommendations for sustainability methodology to submit to the Legislature

December 1, 2012: Report on sustainability is submitted to the Legislature

Premium Aggregation

The Exchange needs to decide whether it will take on the role of aggregating premiums. This means the Exchange would receive tax credits from the U.S. Department of Treasury (Treasury), as well as individuals' premium contributions, and send them on to issuers. Otherwise, tax credits would go directly to issuers from Treasury, and individuals would pay their portion of the premium directly to the issuers. Regardless, individuals have to be given the choice to pay their premiums directly to the carrier, and tax credits would be received by carriers directly from Treasury.

In the SHOP, the ACA requires that the Exchange aggregates premiums. The system will be built to accommodate the SHOP premium aggregation.

The recently enacted HB 2319 also states that the Exchange must adopt policies to allow for various groups to pay premiums on behalf of individuals. Depending on the direction chosen, either the Exchange or participating carriers will have to build systems to accommodate the third party payors.

If the Exchange decides to perform premium aggregation functions, it will be responsible for the ongoing administrative costs of providing those services. If it is left to the carriers, it will likely be built into the premium costs.

Because of already tight timelines, this decision timeline is being influenced by the need of the Exchange IT system integrator to know whether to build this function. Therefore, the timeline is tighter than others.

It is up to the Board on whether premium aggregation will be performed by the Exchange.

May 2012: Staff prepares background information and understands various carriers' position on premium aggregation.

May 2012: The Board is briefed on the premium aggregation issue.

May 2012: Finance/Admin/IT (F/A/IT) Subcommittee discusses premium aggregation. Staff gathers information needed by Subcommittee.

May 2012: Advisory Committee discusses premium aggregation and makes a recommendation to the F/A/IT Subcommittee.

June 2012: F/A/IT Subcommittee makes a recommendation to full Board.

June/July 2012: Board makes a decision on premium aggregation.

Criteria for QHPs

Based on the ACA and HB 2319, it is assumed that the Exchange will use the minimum criteria laid out in the ACA for certifying criteria for qualified health plans (QHPs). Staff have been working to identify the exact data requirements, which program would collect the data (Exchange or OIC), and how to handle some of the required quality measures.

Staff has ongoing meetings scheduled with carriers to work through many of the criteria, recognize their expectations, and reach an understanding as agreeable to both parties as possible.

It is assumed that the Board will want to approve the approach that is being a considered.

May 2012: Staff prepares background information and briefs the Board.

May 2012: Policy Subcommittee considers the specific criteria. Staff gathers information needed by the Subcommittee.

May 2012: Advisory Committee discusses QHP criteria elements and makes a recommendation to the Policy Subcommittee.

June 2012: Subcommittee makes a recommendation to the full Board.

June/July 2012: Board confirms criteria for QHPs.

Consumer Rating System

As part of HB 2319, a consumer rating system is created to help consumers evaluate plans. While not criteria for becoming a qualified health plan, it is the hope that participating plans will provide the information requested for the consumer rating system.

The legislation laid out several rating factors that the Board may include but there appears to be some flexibility in those factors. Staff have had initial conversations with the Puget Sound Health Alliance on the potential to utilize some of their current data collection for certain rating factors laid out in the legislation.

It will be up to the Board to determine what rating factors they would like to see displayed on the Exchange website and whether they would like to add other ratings.

June 2012: Staff prepares background information and briefs the Board. The Board offers its general direction on the issue.

June 2012: Policy Subcommittee discusses the consumer rating system and the Board's general direction guidance. Staff gathers additional information requested by the Subcommittee.

June 2012: Advisory Committee discusses consumer rating system and provides feedback to the Policy Subcommittee.

July 2012: Policy Subcommittee defines an initial set of rating factors and coordinating data sources.

July 2012: Advisory Committee discusses initial set of ratings and provides feedback to Policy Subcommittee.

August 2012: Policy Subcommittee makes recommendations to full Board on the rating factors and data sources.

August/September 2012: Board makes a decision on consumer rating factors and corresponding data sources.

Navigator Program

The ACA lays out the role of Navigators – people who will educate, inform and facilitate enrollment through the Exchange. The Navigator program is a grant program that provides individuals and organizations with funds to help people understand the Exchange, assist with the application process and help to pick a health plan.

The Exchange will administer the Navigator program, which means the Exchange will have to create an infrastructure, a payment model, a training program and performance measures for Navigators. The Exchange is working with Wakely Consulting to ensure this takes place effectively.

The Exchange will also have to determine the best organizations to participate in the Navigator program, representing a wide variety of individuals and small businesses likely to use the Exchange. The goal is to have representative groups from brokers and agents to traditional community organizations who currently help people enroll in Medicaid.

The Navigator program is housed in the Exchange, and no federal funds can be used for the grant program. This means that the program will have be funded through the Exchange's revenue source. This poses a problem because the revenue source may not start until January 1, 2015, and the Navigator program is supposed to start by October 1, 2013 when open enrollment begins. The Exchange will have to find a way to pay Navigators for the first 18 months, if a revenue source does not begin until January 2015.

June 2012: Staff prepares background information for TAC and briefs the Board on the Navigator program. The Board offers general direction on the Navigator program.

June 2012: Board approves the formation of a technical advisory committee (TAC) to advise on the Navigator program. The TAC will likely be composed of stakeholders from the various groups representing those who may be purchasing coverage through the Exchange.

July-August 2012: Navigator TAC meets to discuss Wakely framework and types of organizations to participate in program.

August-September 2012: Advisory Committee discusses Navigator program and Wakely work.

August 2012: Navigator TAC presents their initial findings to the Policy Subcommittee. Subcommittee provides feedback to the TAC.

September 2012: TAC works with Wakely to refine recommendations.

September 2012: Advisory Committee works with TAC on recommendations.

October 2012: TAC presents revised recommendations to Policy Subcommittee.

October 2012: Policy Subcommittee discusses TAC recommendations.

November 2012: Policy Subcommittee makes its recommendations to the full Board.

December 2012/January 2013: Board decides on details of Navigator program.

Role of Agents/Brokers in the Exchange

While agents and brokers may participate in the Navigator program, it is also envisioned that brokers and agents would be able to participate in the Exchange in a more traditional role. As with Navigators, brokers will have a log-in screen on the Exchange web portal that will allow them to view client-specific information and assist clients in applying for and enrolling in coverage.

Another consideration regarding brokers' roles in the Exchange is the compensation model for assisting individuals in signing up for plans. Compensation could be handled as it is today through carrier commissions. Alternatively, broker fees could be paid via a flat fee through the Exchange. This would not alter the compensation model outside of the Exchange.

August 2012: Staff provides background material and briefs Board on agent/broker issues. Board provides general direction on agent/broker issues.

August 2012: Board approves the formation of a technical advisory committee (TAC) to provide input on the role of brokers/agents in the Exchange.

September-October 2012: TAC meets to discuss the role. Advisory Committee discusses agent/broker issues.

October 2012: Advisory Committee works with TAC to on recommendations.

November 2012: TAC makes recommendations to Policy Subcommittee.

December 2012: Policy Subcommittee discusses TAC recommendations.

December 2012: Policy Subcommittee makes recommendations to the full Board.

January/February 2013: Board decides on details of Navigator program.

Dental Plans

The ACA allows for stand-alone dental plans, but HB 2319 requires that stand-alone dental plans be offered in the Exchange. There are no criteria for qualifying dental plans to be offered in the Exchange in the ACA or in state law. Therefore, the Board is responsible for developing the criteria for dental plans, creating a process for approving plans, and structuring fees for paying for the administrative costs of offering dental plans.

June 2012: Staff provides background information and briefs the Board. Board discusses general direction on dental plans in the Exchange.

June 2012: Board approves the formation of a technical advisory committee (TAC) to provide input on offering stand-alone dental plans in the Exchange.

July 2012: Advisory Committee meets to discuss dental plans in the Exchange.

July-August 2012: Dental plan TAC meets to discuss Board's direction on dental plans and develops recommendations for dental plans in the Exchange.

August 2012: TAC presents recommendations to Policy Subcommittee. Policy Subcommittee discusses engaging a consultant to assist in the development of specifics around dental plans in the Exchange.

September 2012: Advisory Committee works with TAC on recommendations.

October 2012: Policy Subcommittee revises TAC recommendations.

November 2012: Policy Subcommittee presents recommendations to the full Board.

November/December 2012: Board decides on specifics of dental plans being offered in the Exchange.